PRINTED: 04/22/2010 FORM APPROVED OMB NO. 0938-0391

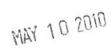
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
445181		B. WII			C 04/04/0040		
	PROVIDER OR SUPPLIER			20	EET ADDRESS, CITY, STATE, ZIP CODE 034 COCHRAN RD ARYVILLE, TN 37803	04/2	21/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 166 SS=D	A resident has the resident have, including those of other residents. This REQUIREMENT by: Based on record residents of other residents. The findings included Resident #6 was resident #6 was residents. The findings included Resident #6 was resident #6	ight to prompt efforts by the levances the resident may se with respect to the behavior. IT is not met as evidenced view and interview the facility rievance for one resident of reviewed. ed: admitted to the facility on April leses including Dementia, and less including Deme		166	This Plan of Correction facility's credible alleg of compliance. "Preparation and/or ex of this plan of correction not constitute admission agreement by the provide the truth of the facts also or conclusion set forth statement of deficienci. The plan of correction prepared and/or execut solely because it is required by the provisions of fewand state law." Right To Prompt Efformed Resolve Grievances Residents concerns about lights are being address an individual basis. Residents using call lighave the potential to be affected.	ecution on does on or ider of leged in the es. is ed uired deral orts To out call sed on this	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

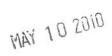
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NAME OF PROVIDER OR SUPPLIER COLONIAL HILLS NURSING CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE 2034 COCHRAN RD MARYVILLE, TN 37803		21/2010		
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F 226	F 166 Continued From page 1 Interview with resident #6 on April 19, 2010, at 3:30 p.m. in the resident's room confirmed the call lights are not answered timely. Telephone interview with the Director of Nursing on April 21, 2010, at 1:40 p.m., confirmed were aware of the problem with call light response time. Continued interview confirmed the staff were last in-serviced on April 14, 2010 on call light response time, the facility is continuing to complete weekly audits by department heads. c/o TN00024811, TN00025376, TN00025370 F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced		F 166	encouraged to use the facility's Concern and Comment Cards to ad facility of call light iss Call light audits and Cand Comment Cards we reported to the Perform Improvement Commit (Executive Director, Inc.)	e d d dvise the ssues. Concern will be rmance ittee Director Director, ector of vity nger, d		
	the facility failed to rorigin for one reside reviewed. The findings include Resident #2 was ad 13, 2007, with diagn Depression, and Co Medical record revie February 5, 2010, rehave a dark purple be Medical record revie	mitted to the facility on April oses including Psychosis, nvulsions. ew of the Nurse's note dated vealed "resident is noted to bruise on top of right hand" w of the facility d February 5, 2010, revealed		Develop/Implement Abuse/Neglect Policie After investigation, if origin of an injury is unknown, it will be repto the State Agency. Any future injury of unknown origin after a thorough investigation be reported to the State Agency.	the ported will		

AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUIL	DING	(X3) DATE SURVEY COMPLETED	
AAF494			G	С		
NAME OF PROVIDER OR SUPPLIER				04/21/2010		
COLONIAL HILLS NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2034 COCHRAN RD MARYVILLE, TN 37803			
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	Continued From page 2 knowledge of any incident and the origin of the bruise is unknown. Interview with the Director of Nursing on April 19, 2010, at 1:30 p.m., in the conference room, confirmed a bruise was noted on February 5, 2010, the origin of the bruise is unknown and the injury of unknown origin was not reported to the State Agency. c/o TN00025376 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.		F 2	the Events Interdiscipli Team. If the event is of unknown cause it will be reported to the State Ag Any reportable event we reported to the Perform Improvement Committee monthly. (Executive	inary of be gency. vill be nance ee fursing, ab focial ctor, cal	
	information to identification resident's assessment services provided; to preadmission screet and progress notes. This REQUIREMENT by: Based on medical refacility failed to main records for three resistant ampled residents. The findings include Resident #1 was additional resident #1 was a	ning conducted by the State; IT is not met as evidenced ecord review and interview, the stain complete medical sidents (#1, #4,#3) of six		Records-Complete Accurate/Accessible Beginning on April 13, Nursing Administration reviews MARs and TA daily, Monday through Friday, for completenes Any omissions are note corrected in a timely far All residents' MARs an TARs are reviewed dail	n Rs ss. ed and shion.	

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			A. BUILDING			С	
445181		B. WII	√G		04/21/2010		
NAME OF PROVIDER OR SUPPLIER COLONIAL HILLS NURSING CENTER			203	ET ADDRESS, CITY, STATE, ZIP CODE 34 COCHRAN RD ARYVILLE, TN 37803			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	52	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	Pancreatitis, Diabed Disease and was of home on October 2 Medical record revidated October 9, 2 (intravenous Cather o saline per each lust (and) PRN (as nee heparin flush per expension of the disease o	stes, and End Stage Renal lischarged from the facility to 26, 2009. siew of the Physician's order 009, revealed "Flush PICC ster) line (with) 10 ml (milliliters) umen q (every) 12 (hours) ded) followed by 1 ml of ach lumen. (change picc line) week and prn" siew of the Medication for the month of October documentation the PICC line tober 10, 11, 17, 25, 2009. evealed the PICC line was shed one time on October 13, riew of the treatment record for aled the only documented as October 24, 2009. Director of Nursing on April 19, in the conference room, re findings and comfirmed the	F	514	All residents' MARs and TARs are reviewed dails corrected timely. If the deficient practice conting the nurse will be counsed Results of these daily as will be reported to the Performance Improvem Committee monthly (Executive Director, Director, Director, Director, Director, Director, Director, Director, Dietary Mang Medical Records, and Pharmacy Consultant).	ly and nues, eled. udits nent rector rector, or of	STrow



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445181		445181	B. WING		04/2	1/2010
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F 514	2010, revealed no or received oral care of Medical record revision April 1, 2010, the no documented oral Observation on April revealed the reside shower per staff. Of at 11:00 a.m., revealed the reside shower per staff. Of at 11:00 a.m., revealed the reside shower per staff. Of at 11:00 p.m., confirmed the above medical record was Resident #3 was acceptuary 5, 2010, who Dementia and Psycon facility to an Assiste 2010. Medical record revision for the 23, 2010, revealed the hydration pass. Medical record revision received the honey hydration pass after Medical record revision for the 20, 2010, revealed to receive the honey hydration pass after Medical record revision pass a	documentation the resident on March 18, 20, 24, 25, 2010. The work the daily care flow sheet rough April 19, 2010, revealed I care on April 3, 4, 18, 2010. If 19, 2010, at 8:30 a.m., and was being prepared for observation on April 19, 2010, alled the resident seated in geril III groomed. In the conference room, are findings and confirmed the incomplete. It in the facility on with diagnoses including hosis and discharge from the are Living Facility on April 9, The work the Physician order 10 revealed "honey thick on cart and hs snack. Medical Physician order dated March mighty shake (honey thick) at the work the hydration pass documentation the resident thick milk shake with	F 514	4		



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F 514	Continued From pa	ge 5	F 5	514			
	on April 21, 2010, a	w with the Director of Nursing at 3:00 p.m,. confirmed the confirmed the medical record					
	c/o TN00025370, T	N00024811, TN00025371					
	6						
	1						

If continuation sheet Page 6 of 6